



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF REGULATION AND LICENSURE
 SECTION FOR LONG-TERM CARE REGULATION

CHANGE OF DIRECTOR OF NURSING IN A LONG-TERM CARE FACILITY

FACILITY INFORMATION

NAME OF FACILITY		
FACILITY ADDRESS	CITY	ZIP
SKILLED NURSING FACILITY <input type="checkbox"/> INTERMEDIATE CARE FACILITY <input type="checkbox"/>		

DIRECTOR OF NURSING INFORMATION

NAME OF THE DIRECTOR OF NURSING	EFFECTIVE DATE OF CHANGE
RN LICENSE NUMBER	STATE ISSUED

PLEASE PROVIDE CONTACT INFORMATION OTHER THAN THE LONG-TERM CARE FACILITY TELEPHONE NUMBER:

TELEPHONE NUMBER	E-MAIL ADDRESS
CELL PHONE NUMBER	OTHER EMERGENCY NUMBER

NAME OF PREVIOUS DIRECTOR OF NURSING

LAST DATE OF EMPLOYMENT

AFFIDAVIT

I attest by my signature that the statements contained in this form are true and correct to the best of my knowledge and belief. I further affirm that I have the express authority to sign this form on behalf of the operator.

AUTHORIZED SIGNATURE	DATE
PRINTED OR TYPED NAME	TITLE OF SIGNATORY

PLEASE RETURN THIS COMPLETED FORM BY MAIL, FAX OR E-MAIL:

**DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SECTION OF LONG-TERM CARE REGULATION
 LICENSURE UNIT
 920 WILDWOOD DRIVE
 P.O. BOX 570
 JEFFERSON CITY, MO 65102**

**FAX# (573) 751-8493
 E-MAIL ADDRESS: LTCAPPLICATION@HEALTH.MO.GOV**